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Realizing policy aspirations of voluntary sector involvement in integrated care provision: Insights from the English National Health Service

Abstract

Integrating voluntary sector organizations (VSOs) into complex health and social care provision is a priority in global healthcare policy. However, realization of these policy aspirations in practice is limited, as VSOs struggle to collaborate with health and social care professionals, or influence the wider healthcare system, undermining their potential involvement in care provision. This paper aims to increase understandings of how the policy implementation gap could be addressed, by asking: how do new workforce roles support VSO involvement in delivering integrated care? Drawing on 40 interviews with VSO workers, healthcare commissioners, and healthcare professionals, conducted over 18 months in the English NHS, we outline how workforce capacity development through the introduction of coordinating roles, coupled with increasing regulatory control of VSO involvement, resulted in enhanced VSO integration in service provision. However, we also warn against the potential for exploitation of VSOs whereby they become replacements for health and social care provision, rather than a complementary service within an integrated team, resulting in patient harm. Our findings have important implications for policy makers, practitioners, VSO leaders and healthcare commissioners. We conclude that policy realization is dependent on the development of coordinating roles, coupled with levels of regulation which protect against exploitation without becoming normatively restrictive, thereby losing the important flexibility of VSOs.

Introduction

I spoke to my manager and said “What do you think? I personally think I should go because I’m not going to sleep tonight if I don’t.” We both went out in the end and we found the lady in a state that I would never wish to find anybody in... and they (social services) never went. They never went because they didn’t have to – she died. There was nothing that we could do. We were too late and she died and I think that was appalling and it didn’t seem to matter what I was feeding back... I was feeding back to social services trying to get some help and get her out of the situation and I couldn’t. You know, nobody... professionally it felt like nobody would take any notice of me - (Voluntary service provider 4)

The vignette above refers to an incident in which a worker from a voluntary sector organization (VSO) made an emergency visit to a frail elderly lady who had waited 19 days for an urgent visit from a social service team, with only VSO provision in the interim. Ultimately this lady died without ever receiving social service care, despite repeated attempts by the VSO to feed back the severity of the situation to them. This distressing incident reflects the distinct imperative, reflected in global policy, for health and social care provision to be more closely aligned, or integrated, with VSOs (DOH, 2016, WHO, 2015). Voluntary services have a potentially positive influence on patient outcomes, as they are able to work with both health and social care providers, crossing institutional barriers (Holder, 2013, Grant et al., 2000). As a result, there is a global policy drive for healthcare commissioners to engage more effectively with VSOs (Baird et al., 2018, Evers and Laville, 2004), particularly in times of austerity and increasing pressure on health and social care resources (Baggott and Jones, 2014).

However, how to implement policy advocating effective involvement of VSOs in the provision of integrated care is unclear (Baird et al., 2018), particularly in healthcare systems where complex and diverse goals, priorities and values are negotiated (Hutchinson et al., 2018). Globally, policymakers and practitioners have attempted to address the implementation gap through a variety of means with limited success, such as top-down mandates that VSOs are included in care provision in Canada (Laforest, 2011), funding incentives in Tanzania (Jennings, 2015), new network structures which include VSOs in the USA (Isaacs and Jellinek, 2007), and workforce development of new roles to facilitate VSO engagement in the UK (Merrell, 2000). However, whilst there has been significant growth in VSOs, and their role in influencing policy or collaborating on research is arguably increasing (Tulloch et al., 2015), they continue to have less influence or power than professional groups or commissioning bodies (Baggott and Jones, 2014, Martin, 2011, Borzaga and Fazzi, 2014).

In this paper we ask ‘how do new workforce roles support VSO involvement in delivering integrated care?’ We consider how VSOs were successfully integrated into service provision by one commissioning organization in the English NHS as a result of workforce development of coordinating roles. Commissioning organizations are responsible for the planning, purchasing and monitoring health services for their local population, and ultimately have oversight for the provision of integrated care. Drawing on 40 interviews conducted over two years we outline how VSO integration was achieved through the use of integrated care coordinators (ICCs), actors positioned between health and social care whose role was designed to facilitate joint working between these two sectors. ICCs occupy full time roles, with 50% of their role funded by the health service, and 50% funded by social care. In this case, individuals taking on these Band 4 roles had previous experience of working in either

health or social services as support staff, but were not trained healthcare professionals or social workers.

Drawing insights from the case of ICCs, we highlight how the policy implementation gap can be addressed through the workforce development of new coordinating roles, illustrating how VSO involvement developed over time, moving from an informal, unregulated model, to a normatively controlled model of integrated care. We show VSOs can enhance the provision of integrated care by ‘bridging’ gaps between health and social care, but warn that this involvement needs to be controlled in order to prevent exploitation of voluntary services. Finally, we advocate for the use of ICCs to realize global policy aims, whilst also highlighting the remaining challenges facing VSOs in the provision of integrated care.

Methods

The empirical context of this paper emerged from a larger study exploring admission avoidance through integrated care commissioning for frail, elderly patients across nine clinical commissioning groups (CCGs) in England, over three years. Commissioning organizations such as this are evident globally (Akbulut et al., 2010, Barnes et al., 2016, Coburn et al., 1997, MacBride-Stewart, 2013), and are responsible for the provision of integrated care by planning and funding healthcare interventions provided by hospitals, community health organizations and other for-profit and not-for-profit healthcare providers.

Following a comparative case study approach (Eisenhardt and Graebner, 2007) of nine commissioning groups in the English NHS, we engaged in longitudinal, qualitative fieldwork consisting of semi structured interviews conducted at two time points (Kvale and Brinkmann, 2009) exploring how commissioning decisions relating to integrated care were made, and

how that changed over time (2013-2015). With assistance from the relevant Chief Operating Officer at each site in exploratory interviews designed to engage commissioning groups in our study, we identified some respondents a priori, and then followed a snowball sampling pattern (Biernacki and Waldorf, 1981), until the themes emerging from interviews were theoretically saturated. To ensure the extended commissioning network was considered, interviews were not limited to those working within commissioning groups, but also encompassed those working in secondary care, public health and local government professionals concerned with provision and commissioning of older people's care, and the voluntary sector.

During the first data collection period at one of the case sites, Eastern Health, the use of Integrated Care Coordinators (ICCs) as a key facilitator of integrated care provision was repeatedly noted in interviews. Integrated care coordinators work across health and social care, where they have oversight of service provision for frail and elderly patients with complex needs. As such, they were able to access information systems for both health and social care providers (which is acknowledged as a key barrier to integrated care, see Currie et al, 2018), whilst also positioning themselves as a 'go-between', facilitating integration by bringing together disparate groups of professionals (Powell and Davies, 2012). In this case, the need for ICCs was identified by commissioners due to a series of events in which health and social services had failed to effectively share information about patients. As such, four Band 4 ICC roles were established to integrate patient referrals for health and social care, to avoid service overlap and to ensure patient information was shared with the appropriate health and social care professionals. The individuals appointed to these roles had previous experience working as support staff in health or social services (for example as health care assistants), but were not trained healthcare professionals. Whilst they were called ICCs in this

context, the establishment of this new bridging role is representative of workforce development attempts seen across a range of global settings (Minkman, 2012, Battersby, 2005).

Following up on this theme, we set out to explore the mechanisms through which ICCs could facilitate the provision of integrated care. We conducted 20 semi-structured interviews at this commissioning organization, interrogating how ICCs worked and why they were well positioned to integrate service provision. During the first round of data collection we conducted interviews with: four integrated care coordinators; three social workers; three community matrons; four general practitioners; one member of the county council; two patient representatives; two general commissioners; and one voluntary sector provider. Interviews lasted between 45 minutes and one hour, and were audio recorded. During these initial interviews, questions were focused broadly on how commissioning decisions were made in relation to integrated care (i.e what kinds of information do you use to make commissioning decisions for services for frail and elderly patients? How do you apply that information to your decision making? What are the key barriers to or facilitators for providing integrated care for frail and elderly patients?). At this time, the role of the ICCs in integrating VSOs into health and social care provision emerged as a key finding.

Following the first set of interviews, and feedback to the commissioning organization which confirmed our inductive conclusions that VSO involvement was a key aspect of the ICC role, we returned for a second round of interviews 18 months later. During the second round we focused on the role of ICCs and their interaction with the voluntary sector in integrated care provision. Specifically, we attempted to answer the research question: how do new workforce roles support VSO involvement in delivering integrated care? We continued to build on our

initial round of data collection by conducting a further 20 semi-structured interviews. These comprised follow-up interviews with: four integrated care coordinators; two general commissioners, one county council member; one social worker; two general practitioners; and two community matrons; and one patient representative. We also conducted new interviews with seven voluntary service providers. Interviews again lasted 45 minutes to one hour and were audio recorded. Questions during this set of interviews focused more specifically on the dynamics of VSO involvement in the provision of integrated care (i.e. can you give me an example of when you've involved VSOs to provide integrated care? What do you think the potential of VSOs are? What are the barriers to or facilitators for involving VSOs in integrated care for frail and elderly patients?).

Informed, written consent was gained prior to all interviews, at both time points. Potential participants were identified through contacts at the commissioning organization, with an initial focus on individuals who were involved in integrated care commissioning, or who worked with the ICCs. At the second round, additional participants who worked with VSOs were approached. We also engaged in snowball sampling to ensure we had not overlooked any key informants. Potential participants were sent an invitation email, alongside a participant information sheet, four weeks before interviews were scheduled. They were also offered the opportunity to ask questions before starting the interview, at which point they signed the consent form. This study received favorable ethical review from the NHS Research Ethics Committee, as well as from the University Research Ethics Committee where the research team were based.

Data analysis was conducted with the assistance of NVivo. The member of the research team who conducted the interviews also led the first round of data analysis, which was guided by

searching for in-vivo codes related to the way ICCs facilitated VSO engagement, challenges they faced from health and social care professionals, and how VSOs responded to their involvement. This was then fed back to the other members of the research team for triangulation and to determine thematic emergence. The research team also sought feedback from the project steering group, consisting of a panel of experts and lay representatives, to further strengthen the data analysis. Over successive rounds of coding and triangulation our codes became more theoretical, and we identified the emergence of different mechanisms facilitating VSO integration over time, as illustrated below.

Findings

Reflecting the longitudinal and relatively inductive research process of this paper, we present our findings as they occurred over time to illustrate how the new ICC roles developed to realize policy aspirations of VSO integration through different mechanisms. We further highlight our findings through Table 1, where we illustrate the change in responses from professionals in health and social care organizations (HSCOs), commissioners and VSO employees as regulatory control and VSO integration into service provision increased.

Table 1 about here

Limited, informal involvement

At the beginning of data collection the ICCs had only been in place for a few months, and as such their role had not yet had a significant impact on the provision of integrated care. When asked about the challenges of their role thus far, all ICCs noted that trying to negotiate

systems barriers between health and social care was inhibitory to the provision of joined up patient care:

I think obviously the funding bit, social care funding and health funding. They've both got their pots and they both want to protect their money and "No, that's not my job, that's health." "No, that's not us, that's social care." I've really just been, you know, in the middle saying "The person needs care. Let's put it in and fight about it later." (first interview – ICC B)

In particular, frustrations centered on funding regulations and professional jurisdictions, with much confusion about *"Is it health? Is it social care? Who's going to fund it? Who's responsible?"* (first interview – ICC C). When asked about how they overcame these service disputes in order to provide care to a patient in need, the ICCs noted their reliance on the voluntary sector, particularly for patients who fell between the 'gaps' of HSCOs:

Not long after I started I had a case with a lady... I think she was due to go in for some surgery and she needed an MRSA wash each day and she could do a certain percentage of her body but she couldn't do her back. So that was basically all it was and healthcare were saying "It's not us, it's a social care need." Social care were saying "No, it's not us, it's a health need" ... in the end I phoned (the VSO) and they did it (first interview, ICC D).

However, despite the ICCs awareness of the potential value of VSOs in providing joined up care to patients, health and social care professionals took a much more skeptical view. VSO involvement was seen as *'a bit of a waste of time sometimes... it's very difficult when you feel*

they've got different priorities' (first interview, community matron 1), with a number of healthcare professionals questioning whether VSOs represented *'value for money... or where we would look to see where you would tighten budgets'* (first interview, general practitioner 4). In particular, professionals working in HSCOs did not have a clear understanding of how or why VSOs could be involved in integrated care provision, noting *'historically there's been some real confusion around volunteer services and voluntary sector organizations'* NN14 (second interview, Integrated commissioning county council 1). As a result of this confusion, any attempt to engage with VSOs was on an ad-hoc, informal basis:

You know, what is the voluntary sector? I mean it encompasses such a wide range of resources and people... it's difficult really because it's a fragmented sector, so it's knowing where you look and for what, and I think there is always a tendency when you're very busy to not have hours to scour around to find out (first interview, social worker 3).

Overall, at the start of the study, whilst the ICCs were beginning to note the potential value provided by VSOs in their ability to bridge the gap between health and social care provision, professionals within HSCOs were more skeptical. This was primarily related to historical concerns around value for money and confusion around how VSOs could be involved in service provision, and how to access VSOs in a time pressured context. Therefore, due to a reluctance to engage with them on the part of health and social care professionals, ICCs struggled to bridge the implementation gap of engaging VSOs in integrated care, rendering their involvement limited and relatively informal.

Increasing involvement and normative control

The second data collection period was conducted 18 months later. At this point, the ICCs had been in post long enough to give an indication of how their role was facilitating integrated care. Most notably, this was achieved through their role in bringing in VSOs. In our field notes at this time point we recorded the split of referrals made by ICCs to VSOs and health or social care organizations in the previous year: health service input 167 patients, social care input 396 patients, voluntary services input 181 patients. Interestingly, at this stage, ICCs were making more referrals to VSOs than they were to healthcare providers. Responses from those working in the voluntary sector also reflected this, suggesting that their increase in referrals was directly related to ICC posts:

When we first started as a service referrals were really slow and we didn't seem to have very good links with health... but when we were put in touch with the integrated care coordinators then the referrals started flowing in (Voluntary service provider 3)

Interrogating this increase in the use of VSOs, responses from both the ICCs and the voluntary organizations suggested their involvement was now facilitated by tighter regulations from the commissioning organization. Whilst VSO involvement had previously been driven on an ad-hoc basis by ICCs to bridge gaps in service provision, tighter control now made funding and procedures for VSO involvement more explicit:

So we're starting to put together a commissioning framework for the voluntary sector... they can come to us and tell us what they can deliver and tell us how they can measure an outcome, tell us how they can meet our objectives. We can't possibly understand the nuances of every voluntary sector organization, but they

can understand the complexities of what we're trying to achieve as a commissioning organization. (second interview, Integrated commissioning county council 1)

Interestingly, in a divergence from the previous model of informal VSO involvement, under the more tightly regulated model commissioners now normatively controlled VSO activities, as the voluntary organizations now needed to demonstrate value for money or outcomes which aligned with commissioning expectations:

What we're hoping to get to is a point where we've got a dashboard to capture this added value – and everybody's really keen to – then we will have some real strong evidence to show why investment in the voluntary sector is worthwhile. (Second interview, general commissioner 2)

Implementing a model of normative control to increase VSO involvement in integrated care had two outcomes. First, it enhanced the role of VSOs in providing joined up care to patients:

We're writing a new service specification so that the Red Cross service targets those that aren't eligible for (Social care). So by making sure that our services line up better it means that people are better supported when they come out of hospital. If you're better supported when you come out of hospital the chances of being readmitted reduce dramatically. So we've started to look at how they fit together (Second interview, general commissioner 1)

Secondly, the bridging role of the VSOs began to alleviate some of the pressure on the resource-strained HSCOs. In particular, workers from VSOs were seen as having more flexibility than health and social care professionals, as *‘health have a more prescriptive way in which they work and social care are limited by resources’* (Voluntary service provider 7). Consequently, workers from VSOs were able to engage with patients outside of tightly regulated professional jurisdictions, as well as spending more time with them:

This is something which in the past healthcare were able to do... but now everything is moving so quickly and everyone's got so many patients there's not enough time, so someone like the Red Cross team are able to give a complete, whole service and it's a free service and patients love it (second interview, ICC D)

At the second point of data collection there was a notable increase in the use of VSOs in providing integrated care. Responses from interviews suggested this was related to two things: the role of ICCs, and increasing regulation from commissioners which normatively controlled VSO involvement. Through these mechanisms VSOs were more substantively involved in bridging the gap between health and social care, alleviating pressure from HSCOs and providing better joined up patient care.

Integration or exploitation?

As noted above, one of the benefits of using VSOs is their higher level of flexibility than HSCOs, meaning that they are able to bridge gaps in service provision. Whilst this is an important element of VSOs, over the course of our interviews we began to uncover instances in which VSOs had done more than bridge service provision, they had been used instead of

HSCOs. As illustrated at the start of this paper, when HSCOs were particularly stretched or under pressure, VSOs were used inappropriately to ‘patch’ service provision:

We don't do emergencies, but where a situation has broken down the ICCs will get hold of us and we need to do something to assist fairly quickly... although we're not an urgent service, if we don't help out and do something then that may mean the person can't stay in their own home. So I've been in the car and there's been a request that's come through and I've turned around (Voluntary service provider 5)

When commissioning managers were asked whether they ever used VSOs to patch services when under resource pressure, a number indicated that they sometimes used the flexibility of voluntary services to their advantage, particularly as they were less likely to refuse to provide services to patients once they were in contact with them, even if it was beyond their VSO remit:

Voluntary sector organizations tend to be a bit more blurred around the edges which means they're not going to sit in somebody's living room saying "No, I'm not going to do that. That's not my job." (second interview, general commissioner)

Therefore, whilst on the one hand the flexibility of VSOs gave them complimentary value to more restricted HSCOs, it also exposed them to exploitation. Some VSO employees noted that *'we're actually not social workers and we're not health workers, but you're made to feel like that sometimes, that you're the last best hope'* (Voluntary service provider 1). In some

circumstances, rather than VSOs providing complementary bridging services with HSCOs, they were used exploitatively in the absence of health and social care, sometimes with undesirable outcomes.

Whilst incidents like the death of a patient were not frequently experienced, there was an awareness by VSOs that they could potentially risk patient outcomes and find themselves in a difficult position by supplementing, rather than complementing, HSCOs. This was particularly at the forefront during times of financial austerity and budget cuts. However, leaders of VSOs also suggested that the increasing regulatory control of the commissioning organization actually enabled them to protect themselves from exploitation. By having clearly defined voluntary roles and jurisdictions, VSOs suggested they were able to push back at the expectation that they deliver services outside of their remit:

You know, suddenly our volunteers or ourselves might find ourselves suddenly trying to somehow orchestrate their support package.... we then go back to say "Okay, our volunteer is now at the limit of what their responsibilities can be or are allowed to be according to the commissioning framework." (Voluntary service provider 6)

Overall, whilst we uncovered some instances where VSOs were arguably exploited, increasing normative control which emerged over time was used to protect themselves from acting beyond their remit. Whilst this arguably reduced their potential flexibility, it was seen as necessary to facilitate VSO involvement in service provision in an integrated, rather than exploitative, manner.

Discussion

This paper set out to explore how workforce development of new coordination roles could address the implementation challenge of realizing policy aspirations of VSOs in integrated care provision. We drew on the illustrative example of integrated care coordinators (ICCs), professionals positioned between health and social care whose role was designed to facilitate joint working between these two sectors. We argue that the main role of the ICCs was to facilitate the involvement of VSOs in a ‘bridging capacity’ to join up gaps in service provision between health and social care, realizing global policy imperatives. However, drawing on insights from our longitudinal research design, we show how the mechanisms for this involvement developed over time.

At the start of data collection, ICCs were new roles which had yet to establish formal mechanisms for VSO involvement. As such, integration of VSOs was on an ad-hoc, relatively informal basis, and other health and social care professionals voiced resistance to working with the voluntary sector due to their nebulous nature. This unregulated model of VSO involvement reflects the challenges of policy implementation noted in previous research (Baggott and Jones, 2014). However, over time we illustrated how increasing levels of normative control by commissioners made VSO involvement in service provision more explicit. As a result, confusion surrounding how ICCs could involve them in integrated care provision was reduced, and the involvement of VSOs increased in line with policy aspirations. However, we also noted that, whilst normative control of VSOs can enhance the provision of integrated care by ‘bridging’ gaps between health and social care, there is potential for VSOs to be exploited by patching or replacing services, rather than complementing them. We illustrated how tighter regulation of VSO involvement could protect against that exploitation. In the following section we interrogate these findings in the

context of existing research and make recommendations for the realization of policy relating to VSO integration in complex care provision.

First, we highlight the importance of workforce development in terms of new bridging roles which act to coordinate diverse professional and organizational groups, and in particular focus on the involvement of VSOs. In this case ICCs represent one version of this role, which Merrell (2000) previously argued were a key mechanism in integrating VSOs in service provision. Whilst existing work suggests confusion surrounding these bridging roles is prohibitive to policy realization, we highlight how the flexibility of ICCs enabled them to work across health, social care and VSOs. However, we also note that ICCs in isolation were not able to fully integrate VSOs due to resistance from health and social care professionals. Instead, VSO involvement only increased when ICC bridging roles were supplemented with increased normative control and regulation from commissioners.

Increased involvement from tighter regulation is potentially counter-intuitive, as it is the associated flexibility of VSOs which add value to integrated service provision (Baggott and Jones, 2014). However, our findings suggested the confusion surrounding VSOs made health and social care professionals skeptical of their value or need for involvement, resulting in limited use of VSOs in service provision. Reducing flexibility over time through increasing normative control arguably acted as a mechanism through which to overcome some of the barriers to integrated care associated with ingrained professional jurisdictions which prevent collaboration (Ferlie et al., 2005, Currie and White, 2012, Currie et al., 2008).

On the one hand, reducing confusion and associated flexibility arguably allowed VSOs to enhance their roles and establish their own recognized jurisdiction (Tulloch et al., 2015). On

the other, whether this was realized in practice is debatable. As noted previously, existing research into integrated care teams suggests more powerful professional groups may exert influence to reinforce professional boundaries, allowing them to achieve their own goals rather than collaborate with other less powerful groups (Easterby-Smith and Prieto, 2008, Todorova and Durisin, 2007, Finn et al., 2010). In this case, commissioners admitted they continued to use VSOs in potentially exploitative conditions, as their flexibility around service provision meant they were able to patch services in times of austerity. In addition, the nature of VSO involvement was led entirely by commissioners, rather than through co-production with VSOs. Voluntary organizations were required to conform to regulated commissioning frameworks, and produce measurable outcomes which were aligned with the goals of the commissioning organizations. As a result, the VSOs in this case continued to struggle to establish authority in relation to more powerful professional groups, potentially undermining their ability to engage in co-production of services (Baggott and Jones, 2014).

However, whilst increasing regulatory control imposed some limitations on the activities of VSOs it also protected them, to some extent, from exploitation. Exploitation of VSO employees in service provision is an ongoing consideration for the involvement of VSOs in integrated care, due to an awareness that they should enhance service provision, rather than substitute for stretched services (Merrell, 2000, Baggott and Jones, 2014). In this case, whilst we note some instances of exploitation, we also note that leaders of the VSOs were able to resist this exploitation as a result of their relationships with ICCs and increased regulatory control over their involvement in service provision. Therefore, it is possible that increased regulatory control enhances the potential for VSOs to engage in co-production of services in non-exploitative ways, ultimately realizing global policy aspirations (DOH, 2016, WHO, 2015).

Whilst these findings have important practice and policy implications this study was conducted in one commissioning organization within the English NHS. As such, implementing national policy in this context may differ from other international settings. Future research should consider how roles similar to ICCs work in other national contexts, and in contexts where levels of regulation may vary. In other words, is increased regulation always possible? Does too much regulation undermine VSO involvement by removing flexibility? Is increased regulation the best mechanism through which to encourage co-production of services of VSOs, or does increased regulation create conditions which might undermine co-production by not treating VSOs as equal partners in the provision of integrated care? Further to this, we acknowledge the limitations of only interviewing three patient representatives as part of the study. Whilst this paper is interested in the interactions between VSOs, health and social care in the commissioning and provision of integrated care, future research should explore how co-production of that integrated care is experienced by patients in terms of increased quality of care. These questions should be answered to give further insight into addressing the policy implementation gap of VSO involvement in integrated care.

Conclusion

This paper has important consequences for the realization of global policy aspirations regarding involvement of VSOs in integrated care service provision. For policy to be effectively implemented policy makers should advocate workforce development of coordinating roles to bridge multiple professional groups. Alongside this they should establish more regulated models of VSO involvement within integrated care teams. The benefits of this are three-fold. First, reduction in confusion about the role of VSOs may

redress some of the professional resistance to VSO engagement previously identified as inhibitory to integration. Secondly, higher levels of regulation protect against exploitation of VSOs as a way to replace, rather than bridge, health and social care services during a period of limited resource. In this way, policy makers and commissioners can prevent circumstances of patient harm such as the one outlined at the start of this paper. Finally, we suggest that increased involvement of VSOs through different models of regulation may create the conditions required to support co-production of services, realizing global policy aspirations (DOH, 2016, WHO, 2015). However, service commissioners, policy makers and voluntary service providers must find a balance when developing models of control for VSO involvement to protect against exploitation without undermining the flexibility which is the potential value of VSOs. Therefore, more work is needed to explore how co-production of integrated care services can be facilitated through alternative models of regulation.

Acknowledgements

This research was funded by an NIHR HS&DR programme grant.

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Table 1: Themes and illustrative quotes

	Limited, informal involvement	Increasing involvement and normative control	Integration or exploitation?
Health and social care professional opinions about VSOs	<p><u>Confusion surrounding role of VSOs</u></p> <p><i>"We just seem to still have this lack of knowledge about what we've got in the voluntary sector, who's doing what, and we know there's elements of duplication" (GP3)</i></p>	<p><u>Increasing recognition of value of VSOs</u></p> <p><i>"GPs can provide obviously medication and diagnosis and all of the medical model things, can't they, and I suppose (VSOs) are much more about the softer bit, the quality of life... There's no point just keeping people alive if their life's terrible, you know, and so I think the doctors really appreciate and they appreciate the VSOs now they've kind of got all of that at their fingertips really" (GP1)</i></p>	<p><u>Increasing awareness of potential benefits of involvement</u></p> <p><i>"Well I don't have enough hours in the day. So yes, if they can go in and do something and it doesn't need a qualified member of staff then why not. If we could work with them a bit closer perhaps we'd have more time to see the patients who need care" (Community matron 1)</i></p>

<p>Regulatory influence from commissioners</p>	<p><u>Limited, informal regulation</u></p> <p><i>"I can think of one particular service that we have commissioned with the Red Cross which has been about providing support in the housing sector and they can't seem to get referrals for love nor money. So we kind of set up things and we didn't specify them closely enough or we left things too loose because we didn't know and our learning is to try to be much tighter around those specifications" (Commissioner 2)</i></p>	<p><u>Increasing normative regulation</u></p> <p><i>"What we're doing through that third sector contract group at the moment is writing a new service specification so that the (VSO) targets those that aren't eligible for (social services)... So by making sure that our services line up better it means that people are better supported when they come out of hospital. If you're better supported when you come out of hospital the chances of being readmitted reduce dramatically. So we've started to look at how they fit together" (Commissioner 1)</i></p>	<p><u>Normative control with potential for exploitation</u></p> <p><i>"We're still working on the service specification but I think we've realized perhaps we don't want to be too specific. Maybe their flexibility is what we need to protect, otherwise they'll start saying they can't do x, y, or z. So we want some regulation obviously, but not so much they (VSOs) start pushing back" (Commissioner 2)</i></p>
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VSO employee experience of involvement	<u>Frustration at lack of integration</u> <i>"It's frustrating I suppose when they involve more than one agency. It kind of feels a bit of a waste of resource. We had a situation where two agencies turned up at the house and some of the agencies are really resistant to kind of working together like that, but (Eastern Health) seem confused about what we all do" (VSO provider 1)</i>	<u>Integration facilitated by relationship with ICC</u> <i>"So (ICCA) basically said to me "Get out there. As soon as you see whatever you see today we'll act on whatever you say," which is a real sort of boost to our organisation that we're trusted and respected that much. And yeah, I mean within the first ten minutes I stepped outside, made the phone call and we had somebody in within six hours. We had the lady in respite within 24, we had the house fumigated and I couldn't have done all of that in that timescale without ICCA" (VSO employee 5)</i>	<u>Increased involvement and awareness of potential exploitation</u> <i>"I think the problem is, when everyone is pushed to the limit and there's no money and no staff, you start looking for ways to patch things up. And on the one hand we should fill the gaps that patients might fall into. On the other hand we need to make sure our staff or our volunteers aren't getting put in risky situations. Risky for them or risky for the patients (VSO employee 3)</i>
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